ANNUAL REPORT

MENTAL HEALTH PATIENT ADVOCATE OFFICE

1993

Alberta HEALTH

ALBERTA
HEALTH

Office of the Minister

Minister Responsible for the Wild Rose Foundation

April, 1994

The Honourable Stanley S. Schumacher, QC
Office of the Speaker
Legislative Assembly of Alberta
Room 325
Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Speaker:

I have the honour to present the Annual Report of the Mental Health Patient Advocate, which summarizes the activities of his office for the calendar year ending December 31, 1993.

Respectfully submitted,

Shirley McClellan
Minister

127 Legislature Building, Edmonton, Alberta, Canada T5K 2B6 Telephone 403/427-3665

Alberta
HEALTH
Mental Health Patient
Advocate Office

12th Floor, Centre West Bldg., 10035 - 108 Street, Edmonton, Alberta, Canada T5J 3E1 403/422-1812

In Replying Please Quote:

March, 1994

The Honourable Shirley McClellan
Minister of Health
Room 127
Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Madam Minister:

It is my pleasure to present the fourth Annual Report of the Mental Health Patient Advocate. This report covers the activities of the Patient Advocate Office for the calendar year 1993; it is submitted in accordance with the provisions of s. 47(1) of the Mental Health Act for your presentation to the Legislative Assembly.

Respectfully submitted,

M. W. Hislop, PhD, R. Psych., CHE
Mental Health Patient Advocate

Contents

The Mental Health Patient Advocate Office

The Mental Health Patient Advocate Office serves as a resource to the psychiatric community — assisting patients to understand and exercise their rights, and investigating concerns or complaints relating to formal patients involuntarily detained in psychiatric facilities designated under the **Mental Health Act**. The Patient Advocate has a legislated, province-wide mandate and reports directly to the Minister of Health. The Minister in turn is required to lay copies of the Advocate's annual reports before the Legislative Assembly at times prescribed in the **Act**.

Anyone may contact the Patient Advocate Office regarding inquiries, concerns or complaints on behalf of any person who is a current or former formal patient; or for the purpose of obtaining general information pertaining to rights and services for persons suffering from mental disorder. Telephone inquiries may be made to the Edmonton office at **422-1812**; calls from locations outside the Edmonton area may be placed free of long-distance charges through local Alberta Government RITE operators. Written contacts should contain as much detailed information as possible, be marked 'confidential' and mailed to:

Office of the Mental Health Patient Advocate
12th Floor, Centre West Building
10035 – 108 Street
Edmonton, Alberta
T5J 3E1.

All contacts are conducted in confidence, and the Patient Advocate Office will not disclose information pertaining to any aspect of investigative activity except as required by law or by the performance of its duties under the **Mental Health Act** and **Patient Advocate Regulation**.

MISSION STATEMENT

To serve as a resource for psychiatric patients by:

- Assisting formal (certified) patients involuntarily detained in facilities designated under the Mental Health Act to understand and exercise their rights;
- Investigating and facilitating redress for concerns and complaints relating to formal patients;
- Assessing and recommending revision to facility procedures for:
  - Admitting persons detained under the Mental Health Act;
  - Informing formal patients of their rights;
  - Providing information as required by the Act to guardians, relatives or designates of formal patients;
- Advocating for amendments to mental health and other protective legislation as these relate to formal patients;
- Offering a consumer oriented source of information for persons with mental illness and others acting on their behalf;
- Supporting client perspectives in the development and implementation of mental health policies and procedures;
- Promoting public, professional and consumer awareness of rights related issues in mental health.

Introductory Comments

1993 has been a year of significant change and challenge for the Patient Advocate Office. Staffing reductions in the office have created considerable pressures in continuing to meet service demands, and have concomitantly impacted caseloads accordingly. The Assistant Patient Advocate, Mr. Marcel Arcand, retired at the end of 1992 after 34 years of public service in this office, the Department of Family and Social Services and the office of the Provincial Ombudsman. He was replaced by Mr. Joseph Kumi, formerly an Area Clinic Manager with the Mental Health Division. The Patient Representative position, formerly held by Ms. Sonja Aspelund, was deleted from our establishment when the incumbent availed herself of the voluntary separation package at the end of March, 1993. The office is now staffed only by the Patient Advocate, Assistant Patient Advocate and a clerical/administrative support person, Ms. Johanna Diepenbroek — reflecting a reduction in investigative manpower of over one third.

Caseloads are down as a result, but not to the same extent as the staffing reductions. This decline reflects both changes in recording methods and the office's diminished capacity to initiate proactive visits to various designated psychiatric facilities around the province with the same frequency as previously. Manpower depletion has also impacted somewhat our promptness of response to incoming calls, and has attenuated as well the public education role played by office personnel. Public presentations are now infrequent, and have required restriction to only those venues which are directly related to office operations. Resource service requests, by contrast, have continued to increase, with the result that overall numbers of issues handled by the office exceeded those recorded last year by about five per cent. The office dealt with a total of 1,431 issues entailing 1,493 personal, telephone or written contacts during 1993; these data reflect a combination of case file and resource service activities.

Despite the noted impacts of diminished manpower resources, the office can continue to cope effectively with current incoming service demands. Patient Advocate Office staff persist as well in ongoing lobbying activities with agencies offering services to mental health clientele; and although no Public Inquiries for formal patients were held in 1993, continue to attend these latter proceedings upon routine notification from appropriate authorities in Alberta Justice. Through active networking with officials in other jurisdictions and the use of local legal update services, the Patient Advocate Office also continues to keep abreast of current developments in protective legislation — including recent courtroom precedents and constitutional/**Charter** challenges impacting mental health law. These and other proactive endeavours are elaborated further in the 'Resource Services' and 'Systemic Issues' sections to follow.

There were no changes during 1993 in the numbers of mental health facilities designated under the **Mental Health Act** as having authority to admit formal patients, although Lethbridge Regional Hospital did become 'operational' for the first time by way of commencing admissions for such patients early in the year. A listing of the thirteen designated hospitals is provided in the Appendices. The proportion of psychiatric inpatients who were certified under the **Mental Health Act** also appears to have remained relatively stable. Current and accurate statistics on mental health clientele have proved difficult to come by over the preceding few years, but my 1990 report did cite an estimate of 2,000 for the total psychiatric inpatient population of the province. Approximately fifteen hundred of these were found to reside in the thirteen designated facilities; of these, about 250 or just under seventeen percent were formally certified and involuntarily detained under mental health legislation at any given time. For 1992-1993, annual data obtained from Alberta Health and a few individual hospitals indicate an estimated 10,600 psychiatric admissions to designated mental health facilities around the province. Over 1,900 of these were reported to be on formal status; thus the proportion who were certified or formally committed under the **Mental Health Act** appears to be just over eighteen percent of all inpatient admissions to designated psychiatric hospitals — an estimate only marginally higher than that obtained from occupancy data three years ago. The term 'estimate' is emphasized here since the data received were incomplete and compiled from multiple sources; both assumptions and extrapolations were required in order to arrive at overall annualized figures. Moreover, some of these data derive from relatively restricted sampling methods conducted directly by this office, and thus may not be all that accurate or reliable.

It should prove interesting to compare these and other psychiatric service statistics over the next few years. These are times of significant social pressures, and indices of social stresses manifest themselves in numerous diverse ways in addition to the direct consumer complaints reported by such sources as a patient advocacy service. Another indicator may be reflected in augmented admission rates to mental health facilities, although this observation could be confounded by current restructuring of the health delivery system and the concomitant de-emphasis of inpatient care in favour of community-based services. Designated psychiatric hospitals, indeed most health care facilities, have undergone significant financial, staffing and operational pressures over the last several months of this ongoing health care reform. There are consequent indications of attendant organizational confusion, staffing pressures, declining staff morale and compromised patient care. Also evident is the reduction or outright abolition of dedicated internal mechanisms for the formal redress of patient concerns in those few progressive hospitals having initiated same.

The role of the Patient Advocate Office has thus seemed to become both more critical and more difficult over this same time period, and perhaps will continue to be so for the foreseeable future. Patient Advocate Office staff have noticed marked qualitative, if not quantitative, changes in calls and concerns coming to the office. Complaints more frequently than formerly reflect alleged inadequacies in standards of care; lack of appropriate attention by nursing, medical or other professional staff; and increased difficulties in placing psychiatric patients via the normal pre-discharge planning process because of diminishing financial resources for these individuals in the community. In order to become more familiar with placement options upon discharge from hospital, the Patient Advocate arranged for an orientation tour of inner-city resources conducted by staff at the Boyle-McCauley Health Centre. The experience proved enlightening; it was also inspiring to witness the dedicated and often unsung work done by both professional and lay contributors alike in serving our disadvantaged citizens in these troubled times.

Activity Summary: Resource Services

Resource services comprise both office initiated lobbying endeavours and response related activities in which the Patient Advocate Office is used as an information source for persons seeking redress on individual problems or systemic matters relating to psychiatric services. Callers are not usually concerned with specific patients in designated mental health facilities in the latter instances, and hence individual case files are not opened. Over one half (55 per cent) of these resource service requests came from concerned citizens; the remainder emanated from a diverse range of agencies including government departments, legal firms, professional associations, MLA offices, consumer organizations, and health or social service providers in several provincial jurisdictions. The Patient Advocate Office dealt with 543 non-case related issues during the year in the course of responding to 393 resource service inquiries. Overall resource contacts increased 12.3 per cent over those recorded last year, and 133 per cent over those documented for 1991; a small portion of this year's increases is also attributable to recent changes in office recording procedures.

As mentioned in the 'Introductory Comments', proactive visits to designated psychiatric facilities were attenuated during 1993 due to staffing reductions occurring at the beginning of the year. Nonetheless, most designated facilities continued to receive on-site visits for the purposes of meeting with patients and staff, both individually and collectively. Hospitals with larger numbers of psychiatric units and patients on formal status were visited more frequently; all designated facilities were contacted on a periodic basis by telephone in addition to any case related contacts or site visits made.

Meetings focusing on a variety of systemic issues were also conducted with the Ethics Commissioner and numerous officials in the Departments of Alberta Justice and Family and Social Services. Periodic meetings continued throughout the year as well with senior Alberta Health officials and key personnel in the Mental Health Division. A few of the topics discussed related to recently enacted or pending legislation: the **Vulnerable Persons Protection Act**; the **Conflicts of Interest Act**; and the **Access to Information and Protection of Privacy Act**, by way of examples. In addition, written commentaries on both the **Conflicts of Interest Act** and the Department of Health's Deregulation Plan were submitted by the Patient Advocate Office for review by appropriate authorities.

On two occasions in September, the Patient Advocate met with the Chairman and staff of the RCMP Public Complaints Commission. Subsequent to an initial information sharing session, the Patient Advocate was requested to make an additional informal presentation at a regional meeting of Chief Superintendents for the provinces of Alberta, Saskatchewan, Manitoba and the Northwest Territories. Relevant provisions of existing mental health legislation were reviewed; and other matters of mutual interest including the 'criminalization' of the men-

tally ill, the preservation of patients' dignity upon police apprehension, concerns regarding the conveyance of persons with mental illness, and inservice education suggestions for RCMP personnel — particularly peace officers in rural detachments — were candidly discussed.

Active liaison and reciprocal referrals continued throughout the year with other agencies offering investigative or support services to Canadian citizens: the offices of the Provincial Ombudsman, Health Facilities Review Committee, Children's Advocate, Human Rights Commission and the aforementioned RCMP Public Complaints Commission. Referrals were occasionally required to parallel offices and agencies in other jurisdictions: the Advocacy Resource Centre for the Handicapped, Advocacy Centre for the Elderly, and Psychiatric Patient Advocacy Office in the province of Ontario. Consultation was also undertaken with officials in the Ministry of Health and the Office of the Provincial Ombudsman in British Columbia. The latter province has recently undertaken an extensive consultation process by way of redrafting its **Mental Health Act** and other related protective legislation. Part of this 'package' involves the proposed development of a dedicated psychiatric patient advocacy service which, like the Alberta model, is seen to have a legislated mandate.

A more complete listing of the collective facility, agency, media and government office contacts made over the year — both proactive and case related — is provided in the Appendices.

Activity Summary: Case Work

The Patient Advocate Office opened 274 new case files during 1993, reflecting a reduction of about 25 per cent from the caseloads reported last year. As indicated in the 'Introductory Comments', this decline reflects primarily the reduction in investigative manpower occurring in December, 1992; and the office's subsequent inability to initiate proactive visits to designated psychiatric facilities around the province with the same frequency as formerly. In fairness, the observed caseload reductions are also in small part artifactual in that they reflect as well changes in office recording procedures. Some items previously documented as case file entries are now more appropriately recorded as resource contacts, thus partly accounting as well for the latter's increases noted in the preceding section.

The number of independent issues emerging from case files alone totalled 888, a figure down only four per cent from the 926 cited for 1992. The former figure represents an average of just over three complaints or concerns per case file, as compared with the 2.5 issues per file noted last year.

The total number of personal, written or telephone contacts engaged in during the course of addressing case related issues over the year was 1,100. This figure results in an overall mean of about four contacts per file — again, up slightly from the 3.5 average observed for 1992.

The annualized data presented in the following graphs and tables delineate various breakdowns of overall case activity; where required, these data are accompanied by appropriate definitions and interpretive comments. Unless otherwise noted, the proportions and breakdowns presented are comparable with previous years' findings.

FIGURE I provides a breakdown of sources for initial case contacts — showing the numbers and proportions from patients themselves, family members and agencies on their behalf, or other alternate sources (friends, neighbours, landlords, other patients, concerned citizens, etc.). Over eighty per cent of initial case contacts took the form of telephone inquiries; the balance were predominantly personal contacts deriving from our periodic prearranged visits to designated psychiatric hospitals. As in previous years, relatively few (three per cent of) initial case contacts were received in written form.

Figure I

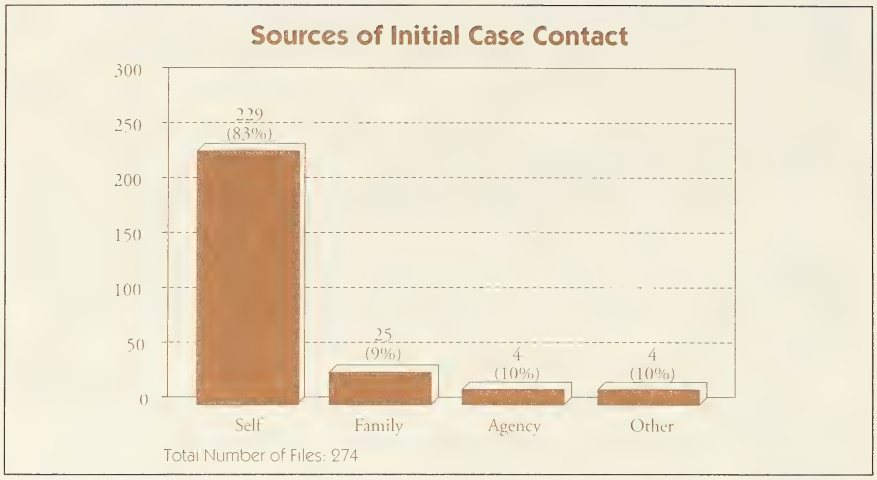


FIGURE II describes the categories of legal status for subjects of call in case activity during the year. The term 'Subject of Call' refers to patients for whom files have been opened and not necessarily to the callers or referral sources involved, although in most instances these individuals are one and the same. The phrase 'Other Involuntary' denotes patients under compulsory detention in designated psychiatric facilities by way of Disposition Orders from the courts or Forensic Boards of Review, Compulsory Care Orders under the **Dependent Adults Act**, or single Admission Certificates pursuant to the **Mental Health Act**. The term 'Other' simply represents a catch-all category for subjects of call not falling into any of the other classifications; for the most part, it reflects persons not currently in hospital and for whom previous admission histories are not known.

Figure II

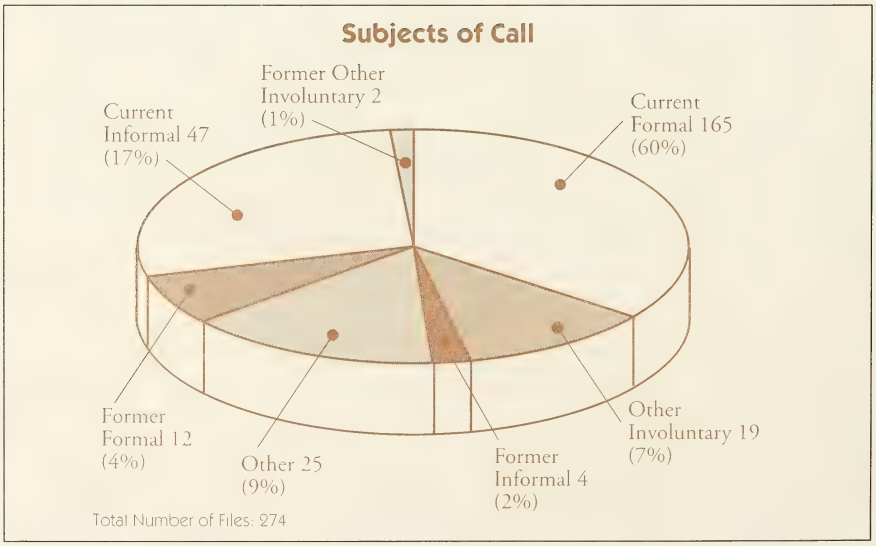
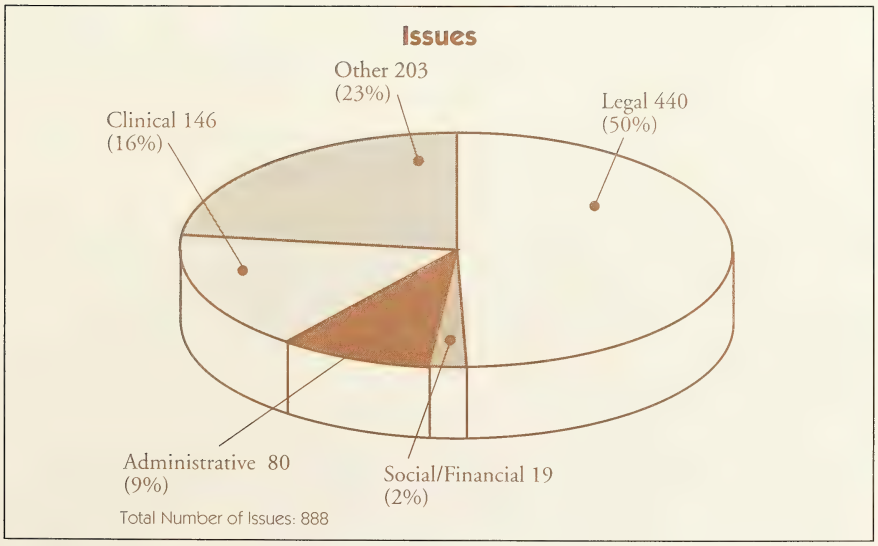


FIGURE III categorizes the major types of issues addressed during the year. These covered a similarly wide range of topics as was witnessed over the previous three years of operation. Once again, by far the most frequently cited concerns were legal in nature — involving certification procedures for formal patients or concomitant rights related inquiries associated with involuntary detention. Probably the most prevalent service routinely rendered by our office is a detailed accounting of rights provisions for patients seeking such information in relation to their own specific situations. The provision of certain minimal rights information is also incumbent on the hospitals, yet a consistently common complaint is the alleged failure of detaining facilities to inform formal patients of their rights as prescribed under **s.14** of the **Act**. These allegations are often difficult to substantiate, since it is acknowledged that certified patients are invariably upset at their involuntary apprehension or detention, and they thus frequently forget much of the information presented at the onset of their hospitalization. In addition, there are no apparent 'patterns' associated with these particular patient complaints; they seem to vary randomly between facilities, between units within facilities, and even over time on the same units. The problem does seem to be exacerbated by administrative and staffing changes — thus pointing to the need for fastidious attention to the ongoing staff development requirements associated with facility reorganization. The Patient Advocate Office has recommended the regular use of a facility generated 'Acknowledgement Form' which specifies that relevant rights materials have been presented and explained; this document can be signed by the patient and placed on the clinical file. Such an administrative requirement underlines the importance of providing rights related information to patients; it can also serve as a protective mechanism for facilities by way of documenting compliance with **Mental Health Act** requirements.

Figure III



Problems pertaining to treatment, standards of care, and appeal procedures for formal patients also comprised frequently presented areas of concern. Other common issues, and those deriving from the system's legal framework, are discussed further in the subsequent section entitled 'Systemic Issues'.

TABLE I speaks to the disposition of case related issues addressed during 1993, illustrating outcomes independently for jurisdictional and non-jurisdictional matters. Of the 888 independent issues presented to the office, 605 or 68 per cent were jurisdictional. This proportion, and all others outlined in **TABLE I**, are again consonant with the parallel data presented for previous years' operations.

Table I
Issues — Disposition

Period January 1, 1993 — December 31, 1993

Disposition	Jurisdictional	Non-Jurisdictional	Total No.	%
R	375	48	423	48
U	14	4	18	2
D	42	33	75	8
D&R	171	194	365	41
NR/NA	2	4	6	1
NR/RNF	1	0	1	–
Total Issues	605	283	888	100

Legend:

R — Resolved
(fully or partially)

U — Unsubstantiated
(verification not obtained, or issue remains sufficiently undefined as to preclude pursuit)

D — Discontinued
(enquiries/investigation dropped by the office or complainant due to lack of ability/need to further pursue; this can include an inability to establish jurisdiction)

D&R — Declined and Referred
(pertains primarily to non-jurisdictional issues when information or informal assistance are inappropriate or insufficient to resolve the matter; for jurisdictional concerns, denotes either that the patient is capable of pursuing remedy via established mechanisms but has made no attempts to do so, or that ultimate resolution is beyond the scope of office authority)

NR/NA — Not Resolved
(remedy not available)

NR/RNF — Not Resolved
(recommendations not acted upon, or investigation/follow-up not yet completed)

It should be explicitly acknowledged in reading this section, indeed in reviewing this entire report, that the very nature of the Patient Advocate Office prescribes a persistent focus on concerns and complaints — what's wrong rather than what's right with the psychiatric service system. It cannot be over-emphasized that there is a great deal that is 'right' with the system, even though most of these positive aspects will generally escape mention in these annual reports.

By way of brief acknowledgement, however, our observations suggest that the Review Panel appeal mechanisms prescribed in the **Mental Health Act** appear to be working proficiently. Individual issues continue to be addressed directly and effectively with the chairpersons involved as these arise. In addition to this ready and ongoing cooperation, it is noteworthy that there have been exceedingly few valid complaints against these administrative tribunals during the four years that this office has been in operation — despite their difficult and sensitive role. Similarly, the legal support system appears to be accommodating most certified patients' needs in satisfactory fashion. Referrals for legal assistance are often made to the Legal Aid Society, which provides representation at Review Panel hearings for the majority of patients contesting their medical certificates. While this service does seem distinctly superior in some parts of the province as compared with others (due apparently to the existence of duty rosters), it is hoped that this very critical legal support for formal patients can continue unabated given current and future financial uncertainties.

Systemic issues should not be confused with 'common' issues such as those cited in the preceding section of this report. Individual concerns regarding involuntary detention, enforced treatment, control provisions of the **Mental Health Act**, or more mundane matters such as smoking policies in the various designated facilities are indeed common issues reflected by relatively high incidences of patient complaint. But these matters are not systemic in that they do not represent pervasive problems that are intrinsic to the overall mental health system and its workings. A number of systemic difficulties derive from inadequacies in the existing **Mental Health Act (Bill 29)**, proclaimed over four years ago in January, 1990. These statutory shortcomings in our legislative framework for mental health services have been mentioned only briefly in previous reports. It is now suggested that they should receive appropriate attention in the reasonably imminent future.

Bill 29 was proclaimed after a lengthy consultation process involving all facets of the mental health community and the public at large. It emulated the **Uniform Mental Health Act**, which was promulgated as a guide for provincial mental health statutes by the Uniform Law Conference of Canada in the late 1980s. This **Uniform Act** was drafted to assist the provinces in better accommodating the **Canadian Constitution** and **Charter of Rights and Freedoms**; it included

explicit provisions for a dedicated psychiatric patient advocacy service.[1] Like the Uniform legislation on which it was closely based, the revised Alberta **Act** embodied stronger protective provisions for certified psychiatric patients, who represent the sole segment of our society which has historically been deprived of fundamental rights and freedoms without the trappings of due process accorded other citizens — including those in our criminal justice system. The **1990 Act** incorporated stricter criteria for psychiatric certification and more clearly defined appeal mechanisms for challenging involuntary detention, treatment matters, and consent competency issues. **Bill 29** also augmented the powers of Mental Health Review Panels, and created the Patient Advocate Office to assist patients involuntarily detained under mental health law in designated psychiatric facilities throughout the province.

Notwithstanding the extent to which preparatory work and public consultation is accomplished, however, many statutes continue to contain unforeseen shortcomings upon enactment. This seems particularly the case with protective legislation, with its attendant complexities, social sensitivities, polarized perspectives and infringements on individual liberties. The Patient Advocate Office has recommended numerous amendments to the Alberta **Mental Health Act** and its associated **Regulations** over the past four years. These suggested statutory revisions range from simple clarifications to blatant gaps in and/or constitutional concerns with the protective provisions of the existing **Act**. A few examples are highlighted here.

— **GAPS**: One of the more flagrant 'gaps' apparent in the current **Mental Health Act** provisions is the lack of a mechanism for valid treatment consent on behalf of formal patients who are deemed incompetent to make their own treatment decisions, and for whom there is no nearest relative meeting the surrogate consent requirements defined in the **Act**. The Patient Advocate Office has recommended that Review Panels be legally authorized to become involved in these instances, as they already are for competent formal patients when Treatment Orders are sought by their attending physicians.

A question has also been raised regarding apparent discrepancies between the Common Law and **Mental Health Act** provisions vis-a-vis the ability of competent minors to give informed treatment consent. Except in cases of mentally incompetent persons for whom there is a Compulsory Care Order or a court-appointed guardian, it is generally accepted by the Common Law that consent validity for medical interventions intruding on one's person is dependent on the capacity to comprehend clinical information and give informed consent rather than on age *per se*. In Alberta, competent formal patients under the age of major-

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[1]Developed collaboratively with seven provincial jurisdictions, the **Uniform Mental Health Act** (1987) served only as a 'model' statute. Unlike those of its contemporary US Federal counterparts, the **Protection and Advocacy for Mentally Ill Individuals Act** (1986) and amended **Protection and Advocacy for Individuals with Mental Illness Act** (1988), its advocacy provisions were not binding on the provinces.

ity (eighteen) are denied the right of consent under current **Mental Health Act** provisions; there are no explicit expectations prescribed for even involving competent youth in the consent process for their own care and treatment.[2]

Another suggestion has focused on the absence of advance notice provisions for persons in respect of whom Warrants for Apprehension are issued by a provincial court judge under **s.10** of the **Act**. It is recognized that in many instances such notifications are untenable given the mental or emotional state of the individuals involved. Nonetheless, it has been recommended that, where feasible, notice be served on the subjects of such warrants in order that they are accorded opportunity to speak on their own behalf when issuance of a warrant is being considered. Brief examples are perhaps in order here to illustrate the impact of this omission, with its attendant absence of due process and procedural safeguards against unwarranted apprehension. In one instance, not occurring this year, a prospective patient attended at a psychiatric facility seeking assistance, but was clinically assessed as not requiring admittance to the hospital as an inpatient — even on a voluntary basis. Referrals to appropriate outpatient services were made. Yet within 48 hours, the actions of a relative resulted in a warrant for this person's involuntary apprehension by the police at her place of residence, and she suffered the added indignity of being compulsorily conveyed at an awkward hour to yet another facility for a repeated and redundant psychiatric examination — with the same resulting clinical decision. In other cases, callers have alleged that judgements rendered in divorce or custody proceedings have been unfavourably influenced by the stigma associated with unreasonable but incontestable Apprehension Orders initiated by their spouse or another third party.

— **CLARIFICATIONS**: A number of provisions and procedures in the **Mental Health Act** require clarification. One of these relates to the forms prescribed in the **Regulations** pursuant to the **Act** — particularly Form 12 pertaining to Review Panel applications. This form currently serves several purposes relating to four separate sections of the **Act**. We would normally argue against a multiplicity of forms, but in this instance the Patient Advocate Office has suggested that the various reasons for completing Review Panel applications be both clarified and reflected by the use of separate, dedicated documents. At the very least, the form completed by physicians applying for Treatment Orders should be separate from the form(s) completed by patients requesting transfers to correctional facilities, contesting their Admission/Renewal Certificates, and/or appealing their Physicians' Certificates denoting their incompetence to make informed treatment decisions. Confusion resulting from the current single form introduces inefficiencies and delays in arranging panel proceedings because of the requirement for

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[2]Similar concerns have prompted recent amendments to British Columbia's **Infants Act**. Denial of capable young persons to provide informed consent for their own treatment was seen to be not only at variance with the Common Law, but also potentially unconstitutional and in violation of **s.15** of the **Charter**.

constantly clarifying patients' intentions with respect to their submitted applications for review.

— **CONSTITUTIONAL CONCERNS**: Of particular significance for health service consumers is the singular lack of rights provisions for persons apprehended and/or involuntarily detained under a single medical certificate pursuant to **s.4(1)** of the **Act**. Such citizens are in compulsory custody, but they are not subject to any of the protective provisions accorded formal patients until such time as a second Admission or Renewal Certificate is completed by the detaining facility. One medical certificate is sufficient authority to "apprehend . . . convey . . . care for, observe, examine, assess, treat, detain and control" a person involuntarily. But there are no explicit provisions for informed treatment consent, for appeal, for clinical or rights related information, or for legal advice and support. The concerns of these patients at a time of obvious trauma are not even jurisdictional for this office until the certification process has been fully completed.

There are undoubtedly other **Charter** related questions to be raised regarding the **Mental Health Act** as well — such as the constitutionality of Treatment Orders for formal patients deemed competent to make their own treatment decisions, and the absence of incompetent patients' prior known wishes when competent as a factor in the provisions for surrogate consent. It is left to the constitutional lawyers and Department legal advisors, however, to define and debate such matters in the course of an upcoming legislative review.

— **OPERATIONAL CONCERNS**: Several recommendations have been made pertaining to the terms of reference for the Patient Advocate Office. One of these entails explicit protective provisions for complainants — similar to the 'whistle blower' clauses recommended by the Provincial Ombudsman. Another seeks staff protection against compulsory court appearances — an important consideration given the tendency to use offices of this nature as free investigative services for potential civil actions in the courts. A provision has also been requested to protect Patient Advocate Office personnel against legal proceedings deriving from their legislatively mandated activities unless it is shown that the office has acted in bad faith. The latter two provisions are similar to those prescribed under **s.24** of the **Alberta Ombudsman Act**.

It has been recommended as well that the Patient Advocate's mandate be broadened to include all psychiatric inpatients residing in those facilities designated under the **Mental Health Act**. These include:

- formal (certified) patients;
- persons detained involuntarily under **s.10** Apprehension Orders or single Admission/Renewal Certificates pursuant to the **Mental Health Act**;
- informal (voluntary) psychiatric patients;

- persons involuntarily detained in designated Forensic Units under Court or Board of Review Disposition Orders;
- persons detained under Compulsory Care Orders pursuant to the **Dependent Adults Act**.

Only concerns of certified patients are currently jurisdictional. Lack of authority to intervene on behalf of persons apprehended under **s.10** of the **Mental Health Act**, or detained on only one Admission/Renewal Certificate under the **Act** seem particularly questionable omissions given the underlying intent for creating this office.

It has been argued that informal or voluntary psychiatric patients have the same rights as all general citizens, and thus have no need for intervention by an advocate. Moreover, setting up a separate support process for informal patients has been said to deter normalization of the mentally ill into mainstream health care. Many informal patients, however, fully meet the criteria specified in the **Mental Health Act** for certification, but are not committed and detained involuntarily simply in order to foster more positive therapeutic relationships. These patients would be certified if they attempted to leave the facility, and they often reside in equally restrictive or 'secure' environments as their formally committed co-patients. Many patients in all the above categories are sufficiently ill, confused, angry and/or anxious that they are unable to speak or act effectively on their own behalf. They thus can have need of the support, advice, information and investigative/complaint resolution services provided by an independent advocate, as witnessed by the fact that over one third (36 per cent) of the initial case contacts our office receives consistently come from such non-jurisdictional sources. This proportion is likely to increase with current/future health care restructuring and concomitant cutbacks in facility funding.

But problems posed by the current lack of authority to assist these patients are not simply philosophical or clinical; practical and legal problems also persist due to the restrictions allowing intervention only when two medical certificates are in effect. Inefficiencies are enforced by the fact that, in many instances, more time and contacts are devoted to determining the jurisdiction of individual issues than to resolving the concerns and problems presented by patients. The office has also been involved in a lengthy and costly civil action deriving directly from these legal limitations. Previous reports have acknowledged that it is awkward for any office to advocate on its own behalf with respect to augmenting its statutory authority without appearing parochial or self-serving. But there are no territorial issues here; the objective is to simply establish a rational, viable mandate for office operations that is consonant with both past practices and the protective provisions previously accorded all psychiatric patients in designated mental health facilities.

Appendices

Agency Contacts

Alberta Government Departments and Offices:

Alberta Community Development

- Women's and Seniors Secretariat

Alberta Family and Social Services

- Appeal and Advisory Secretariat
- Assured Income Programs
- Children's Advocate
- Deputy Minister
- Public Guardian

Alberta Health

- Acute and Long Term Care Division
- Corporate Services and Management Support Division
- Deputy Minister
- Health Care Insurance Division
- Health Facilities Review Committee
- Health Strategy and Evaluation Division
- Mental Health Division
  - Provincial office
  - Regional offices
  - Regional clinics
  - Review Panel Chairpersons
- Minister
- Public Health Division

Alberta Justice

- Attorney General
- Civil Law Division
- Crimes Compensation Board
- Family Court Services
- Fort Saskatchewan Correctional Centre
- Legal Research and Analysis Division
- Public Trustee
- Remand Centre
  - Calgary
  - Edmonton
- Victims' Programs and Services

Alberta Labour
- Human Rights Commission

Ethics Commissioner

MLA offices:
- P. Barrett (Edmonton — Highlands)
- B. Collingwood (Sherwood Park)
- L. Decore (Edmonton — Glengary)
- D. Fowler (St. Albert)
- A. Germain (Fort McMurray)
- M. Henry (Edmonton — Centre)
- B. Hewes (Edmonton — Gold Bar)
- K. Kowalski (Barrhead — Westlock)
- K. Leibovici (Edmonton — Meadowlark)
- D. MacDonald (Three Hills)
- A. McEachern (Edmonton — Kingsway)
- J. Yankowsky (Edmonton — Beverly — Belmont)

Premier's Council on Persons with Disabilities

Provincial Ombudsman

Other Government Departments and Offices:

British Columbia Ministry of the Attorney General
- Public Trustee

British Columbia Ministry of Health
- Mental Health Division
- Sr. Health Law Consultant

Edmonton Board of Health

Health and Welfare Canada: Ottawa, Ontario

Provincial Ombudsman: British Columbia
- Vancouver office
- Victoria office

RCMP
- Public Complaints Commission
- Provincial Superintendents
  - Alberta
  - Manitoba
  - Northwest Territories
  - Saskatchewan

United States Consulate: Calgary

Facilities:

- Alberta Hospital Edmonton
- Alberta Hospital Ponoka
- Calgary General Hospital
- Charles Camsell Provincial General Hospital
- Foothills General Hospital: Calgary
- Fort McMurray Regional Hospital
- Fort Saskatchewan General Hospital
- Grey Nuns Hospital
- Holy Cross Hospital: Calgary
- Lethbridge Regional Hospital
- Medicine Hat Regional Hospital
- Misericordia Hospital
- Queen Elizabeth II General Hospital: Grande Prairie
- Riverview Hospital: Coquitlam, British Columbia
- Royal Alexandra Hospital
- University of Alberta Hospitals

Community Agencies and Organizations:

- Alberta Association for Community Living
- Alberta Health Association
- Alberta Nurses Association
- Boyle-McCauley Health Centre
- British Columbia Health Association
- Canadian College of Health Service Executives: Ottawa, Ontario
- Canadian Institute of Law and Medicine: Toronto, Ontario
- Canadian Mental Health Association
    - Provincial office
    - Regional offices
- Changes
- Citizen's Commission on Human Rights
- College of Psychologists of British Columbia
- Community Connections
- Cook Duke Cox
- Edmonton Regional Day Centre Society
- Excel Resources Society
- Edmonton Social Planning Council
- Everglades Special Care Home: Carvel
- Fort McMurray Health Unit
- Homewood Health Centre: Guelph, Ontario
- Janssen Pharmaceutica: Toronto, Ontario

- Law Reform Institute of Alberta
- Legal Aid Society of Alberta
  - Provincial office
  - Regional offices
- Manor House
- McCauley Sr. Citizen's Lodge
- Meadows Lodge
- Mill Creek Centre
- Ontario Board of Examiners in Psychology: Toronto, Ontario
- Pearl Villa Homes Ltd.
- Peterson Hustwick Wetsch and Moffat
- Psychiatric Patient Advocate Office: Toronto, Ontario
- Schizophrenia Society of Alberta
- Single Men's Hostel
- Support Network
- University of Alberta
  - Faculty of Extension: Legal Resource Centre
  - Faculty of Law
  - Faculty of Nursing
- University of Ottawa
  - Faculty of Law
- YWCA
  - Housing Program

Media Contacts:

- Calgary Herald
- CBC Newsworld
- CBC Radio
- CKKX: Calgary
- Edmonton Journal
- Globe and Mail: Toronto, Ontario
- Government of Alberta Newsletter
- Southam Information and Technology Group: Toronto, Ontario
- St. Albert Gazette

Facilities Designated Under The Mental Health Act

The following fourteen hospitals are designated under the **Mental Health Act** as facilities for the care, observation, examination, assessment, treatment, detention and control of persons suffering from mental disorder:

- The Alberta Hospital Edmonton;
- The Alberta Hospital Ponoka;
- The Calgary General Hospital:
  - Bow Valley Centre;
  - Peter Lougheed Centre;
- The Caritas Health Group:
  - Grey Nuns Hospital, Edmonton;
  - Misericordia Hospital, Edmonton;
- The Foothills Provincial General Hospital, Calgary;
- Fort McMurray Regional Hospital;
- The Holy Cross Hospital, Calgary;
- Lethbridge Regional Hospital;
- Medicine Hat Regional Hospital;
- Queen Elizabeth II Hospital, Grande Prairie;
- Royal Alexandra/Charles Camsell Hospitals, Edmonton;
- University of Alberta Hospitals, Edmonton.

The Forensic Services Unit of The Calgary General Hospital and The Alberta Hospital Edmonton are designated as facilities for the purposes of **s.13** of the **Act**.

Mental Health Act

Part 6 — Mental Health Patient Advocate

Definition

44 In this Part, "Patient Advocate" means the Mental Health Patient Advocate appointed under section 45.

Patient Advocate

45(1) The Lieutenant Governor in Council shall appoint a Mental Health Patient Advocate, who shall investigate complaints from or relating to formal patients and exercise such other powers and perform such other duties as are prescribed in the regulations.

(2) The Lieutenant Governor in Council may make regulations

(a) respecting the powers and duties of the Patient Advocate;

(b) requiring boards to make available any information referred to in the regulations for the purpose of an investigation by the Patient Advocate.

Employees and advisors

46(1) In accordance with the Public Service Act there may be appointed any employees required to assist the Patient Advocate in performing his duties under this Act.

(2) The Patient Advocate may engage the services of lawyers, psychiatrists or other persons having special knowledge in connection with his duties under this Act.

Annual report

47(1) As soon as possible after the end of each year, the Patient Advocate shall prepare and submit to the Minister a report summarizing his activities in that year.

(2) On receiving a report under subsection (1), the Minister shall lay a copy of the report before the Legislative Assembly if it is then sitting, and if not, within 15 days after the commencement of the next ensuing sitting.

Mental Health Act

Patient Advocate Regulation

Table of Contents

Definitions

1 In this Regulation,

(a) "Act" means the Mental Health Act;

(b) "formal patient" includes a person who has been a formal patient;

(c) "Patient Advocate" means the Mental Health Patient Advocate appointed under the Act.

Delegation

2 The Patient Advocate may in writing delegate to any person holding any office under him any power or duty conferred or imposed on him under the Act or the regulations under the Act, except the power of delegation in this section and the power or duty to make any report under the Act or regulations.

Power to act on a complaint relating to a formal patient

3(1) On receipt of a complaint from or relating to a formal patient, the Patient Advocate

(a) shall notify the board of the facility in which the formal patient is detained of the nature of the complaint,

(b) shall notify the formal patient, in writing, that a complaint has been received, of the nature of the complaint and of any investigation arising from the complaint,

(c) if a person other than a formal patient is named in the complaint, shall notify that person of any investigation arising from the complaint, and

(d) shall make any contact with the formal patient and conduct any investigation of the complaint that the Patient Advocate considers necessary.

(2) If a complaint relates to a formal patient who has been transferred from one facility to another, the notice under subsection (1) (a) shall be provided to the boards of both facilities.

(3) A formal patient and a person who has received notice of an investigation under subsection (1) (c) has the right to make representations to the Patient Advocate relating to the complaint.

(4) The Patient Advocate may investigate a complaint only as it relates to the period during which the person who is the subject of the complaint was subject to 2 admission certificates or 2 renewal certificates.

(5) On receipt of a complaint, the Patient Advocate shall provide to the formal patient and to the complainant, as far as is reasonable, information respecting the following:

(a) the rights of the formal patient under the Mental Health Act;

(b) how the formal patient may obtain legal counsel;

(c) how to make an application to the review panel;

(d) how to commence an appeal to the Court of Queen's Bench.

Power to initiate an investigation without a complaint

4 The Patient Advocate may, without receiving a complaint, initiate and conduct an investigation into

(a) any procedure of a facility relating to the admission of a person detained in the facility pursuant to the Act, and

(b) any procedure of a facility

(i) for informing a formal patient of his rights, or

(ii) for providing information as required by the Act to guardians, nearest relatives or designates of a formal patient.

Procedures

5(1) The Patient Advocate

(a) shall maintain a record relating to every complaint and every investigation under this Regulation, and

(b) may make any inquiries he considers necessary to conduct an investigation.

(2) The Patient Advocate shall notify the board of a facility of his intention to contact a patient or a formal patient of the facility and the board shall grant the Patient Advocate access at all reasonable times.

(3) The Patient Advocate shall notify the board of a facility of his intention to carry out an investigation that relates to the facility, whether the investigation arises pursuant to section 3 or 4.

(4) The Patient Advocate is not required to hold a hearing.

(5) If the Patient Advocate requests in writing from the board of a facility

(a) any policy or directive of the facility,

(b) any medical or other record or any information, file or other document relating to a patient or a formal patient who is the subject of an investigation under section 3 or 4, or

(c) any other information, file or document relating to an investigation under section 3 or 4,

the board shall, within a reasonable time after receipt of the request, provide access to the materials requested.

(6) If the Patient Advocate so requests, the board shall provide a copy of any materials requested under subsection (5).

Disclosure

6 The Patient Advocate shall not disclose information obtained in the course of an investigation except as required by law or in the performance of his duties under the Act or this Regulation.

Report

7(1) On completion of an investigation, the Patient Advocate shall prepare and send to a board a copy of the report of the investigation.

(2) A report that contains recommendations shall state the reasons for the recommendations.

(3) If a report is sent to a board under subsection (1) and within a reasonable time after the report is sent to the board the Patient Advocate is of the opinion that the board has not taken appropriate action on any recommendation, the Patient Advocate shall send a copy of the report and the board's response, if any, to the Minister.

Frivolous complaint

8 The Patient Advocate may refuse to investigate or cease to investigate a complaint if in his opinion

(a) the subject matter of the complaint is trivial,

(b) the complaint is frivolous or vexatious, or

(c) having regard to all of the circumstances, no investigation is necessary.

Notice to complainant

9 The Patient Advocate

(a) shall inform a formal patient of the disposition of any complaint that relates to the formal patient, and

(b) may inform a complainant of the disposition of any complaint initiated by the complainant.

Coming into force

10 *This Regulation comes into force on January 1, 1990.*